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The Need for a Process Theory: Formulating Health Policy through Adjudication

Margaret G. Farrell
Yeshiva University

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THE NEED FOR A PROCESS THEORY: FORMULATING HEALTH POLICY THROUGH ADJUDICATION

MARGARET G. FARRELL

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I. INTRODUCTION

For several years health care reform proposals have had a prominent position on the front pages of our daily newspapers and in our nightly newscasts. Although the future of these proposals is uncertain, concern over the nation's system for delivering health care will persist and provoke debate over the creation of substantive rights to health care. However, there are important procedural issues that seem to get lost in the debate. These include questions about how courts, administrative agencies, private arbitrators, institutional ethics committees, etc., should be used to settle controversies between providers, insurers, patients and health plan subscribers over the enforcement of those rights. Despite the absence of discussion of these procedural questions, it seems clear that the disposition of patient and provider

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1Associate Professor, Yeshiva University, Benjamin N. Cardozo School of Law. The author is grateful for the excellent assistance in writing this article provided by Christopher Bowes, a student and research assistant at Cardozo School of Law.
claims will greatly affect not only the lives of millions of people and the functioning of state and federal courts,\textsuperscript{2} but also the formation of substantive health policy. This article suggests that we begin to construct an analytic framework based in legal process theory and health policy analysis within which to evaluate mechanisms for resolving individual claims to health care and treatment.

If health care reform legislation, on the state or federal level, transforms our predominantly private health system into a more public one, the dispute resolution procedure mandated by legislation or administrative regulations will become an increasingly important mechanism through which public health care policy is formulated. Substantive decisions made by hospitals, insurers, administrative agencies and courts in resolving individual controversies about who gets what health care, at whose expense, will gradually establish much of our nation's health care policy. This policy, developed on a case-by-case basis, will be every bit as important to the achievement of the reform's objectives as the policy embodied in legislation or administrative regulations.

Although some health care reform legislation may be enacted on the federal level, increasing attention is being given to state reforms. Many of the national proposals anticipate that the states will play a major role in shaping their health care systems within a national framework of goals and limitations.\textsuperscript{3} Already, more than seven states have enacted major health care reforms without waiting for direction from the federal government.\textsuperscript{4} Given this new role over the next several years, state as well as federal legislators, regulators, insurers, and providers who have authority under reform legislation to locate and design adjudicatory institutions will have to choose among the process options, the theoretical foundations, and the ethical models available. They will need some guidance.

Yet, policy makers have no theory of process\textsuperscript{5} upon which to decide which institutions and procedural models should be used to settle the array of health care claims that will arise. It appears that in an effort to get the substance right, policy makers have paid little attention to process. Even though all of the health


\textsuperscript{3}Richard Kronick, \textit{Where Should the Buck Stop: Federal and State Responsibilities In Health Care Financing Reform}, 12 \textit{Health Affairs} at 87 (Supp. 1993).

\textsuperscript{4}\textit{Symposium on State Health Care Reform}, 12 \textit{Health Affairs} 7 (Summer 1993).

\textsuperscript{5}As used here, "process" means the forums, decision makers and rules of procedure used to define issues, control participation and resolve health care disputes. A "theory of process," means the abstract principles and values upon which particular procedures or procedural models depend.
care reform proposals recently debated in Congress sought to provide universal access to health care for all Americans (though not necessarily universal coverage), few proposals set forth the procedures through which these new individual rights to access could be claimed. Moreover, policy makers have few analytic tools with which to choose from among the dispute resolution alternatives open to them. While some health care reform proposals have provisions for enforcement of the entitlements they create, none appear to base such processes on a principled, coherent analysis of the procedural options available.

This essay sets out a preliminary, theoretical framework within which to analyze remedial options and begin the search for the values they promote. It is based on the premise that the process used to enforce substantive rights to health care should promote values that are consistent with, and even supportive of, the values that health care reform itself would promote. The framework proceeds upon an analysis of the kinds of claims at issue, the alternative decision making models available to settle them, and the forums in which those models might be used. In conclusion, I urge scholars, policy makers and practitioners to consider procedural as well as substantive issues in developing health care reform proposals so that the implementation of new rights will support the objectives of health care reform.

Under the present system (or non-system), individual patient and provider complaints raising issues about access to treatment, the quality of care and the cost of health services are adjudicated in a bewildering legal matrix of forums and procedures. Often the issues in these disputes are defined in terms of claims to legal rights and are resolved by courts. But courts are not the only forums available and their formal rules of evidence and civil procedure are not the only standards which can be used to resolve such claims. Individual claims brought under the new legislation will have to be settled in some forum—private, administrative or judicial—that is given jurisdiction over them under the new system. Currently, policy makers must create the forums and procedures for resolving these claims without suitable analytic tools or sufficient information upon which to base their judgments. In the absence of factual information about the effect of various resolution procedures upon the outcome of disputes, I suggest that we look to theoretical models described in legal and health policy literature to develop a framework within which to construct a new system for the resolution of health care claims.

II. THEORETICAL FRAMEWORK

Only a limited amount of empirical data is available to policy makers about the effects of different adjudication models on the substance of resulting

decisions. Such empirical information is difficult to gather because so many variables affect adjudicatory decisions. These variables include, but are not limited to, the number of parties, their dealings with each other, the economic and other consequences of various outcomes, the procedures used to resolve their disputes and the nature of the decision makers. Where there is data showing an association between certain procedural variables (e.g., the requirement of a written decision) and certain outcomes (e.g., decisions in favor of the status quo), it should be taken into account in designing patient dispute resolution. Very little such information is available.

On the other hand, there is a considerable body of literature describing the effect of legal procedure on substantive decisions that is based on impression, anecdote, philosophical analysis, and insight. This literature seeks to determine the theoretical basis for various kinds of decision making processes. That is, it describes the claims processes used by public and private insurers, alternative dispute resolution, administrative procedure, and the judicial process in an effort to identify the moral, economic, and jurisprudential principles and values that underlie them. The insights provided by this literature can serve as a useful starting point for an analysis of existing and proposed procedures through which we might resolve health care disputes.

In addition, there is a separate literature that seeks to identify the moral, economic, and political underpinnings of national health policy. For example,

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10 See generally, ELI GINZBERG, HEALTH SERVICES RESEARCH: KEY TO HEALTH POLICY (1991); Margaret G. Farrell, Legal and Ethical Issues in the Regulation of Health Care, 1 BIOLAW 333 (1987).
health policies that promote informed consent rest heavily upon philosophical and ethical principles of individual autonomy and rationality.\textsuperscript{11} A synthesis of these two discourses, legal process theory and health policy analysis, can be used to fashion a new theoretical framework within which to evaluate options for the formulation of health policy through adjudication.

A. Allocative Decisions

To begin to define this theoretical framework, we can make a distinction between aggregate consumer claims for more health care services in relation to other goods and services (how big the health care pie should be) and individual claims for treatment (who should get a piece). A logical starting point is the premise that in this world of limited resources one of the major functions of any new health care system will be to ration health care.\textsuperscript{12} Rationing can be conceived of as requiring decisions on two levels. First, as a society, we must make "allocative decisions" about how much of our social resources will be devoted to health care and how much to other goods and services.

In a free enterprise system, most allocative decisions are made invisibly by participants in capital markets who seek to maximize their profits and preferences by directing resources to their most valued use, including health care.\textsuperscript{13} Sometimes, however, such allocative decisions are made collectively through government regulation rather than by individuals participating in markets. For example, in an effort to control health care expenditures some states control investment in health care facilities through their certificate of need programs rather than letting market forces dictate such investment.\textsuperscript{14} Health care reform proposals are largely concerned with collective allocative decisions to be made through government regulations mandating health benefits, compelling insurance coverage, and capping aggregate health care expenditures.

B. Distributive Decisions

In rationing health care, we must also make "distributive decisions" about who will receive the aggregate resources we have allocated to health care.\textsuperscript{15}


\textsuperscript{15}See generally Guido Calabresi \& Philip Bobbitt, Tragic Choices (1978).
This allocation, in turn, depends on the distribution of wealth among individual participants. The invisible hand provides more goods and services to those with funds to purchase them than to those lacking such funds. Individuals in a market system cannot claim a legal right to health care they cannot afford. Under some health care reform proposals, for example President Clinton’s Health Security Act, access to health care would be provided to all at an affordable premium (paid jointly by employees and employers) or a subsidized premium (paid by government) for those without sufficient funds. Under such proposals, distributive claims—claims of individuals that they are entitled to a piece of the pie—will consist largely of the claims of individual patients who complain that they are not getting the kind, amount, or duration of care they are entitled to receive.

Patients will make several kinds of distributive claims under newly reformed health care systems that require determinations about how health care resources are allocated. First, patients will claim that they are entitled to different levels of insurance benefits, subsidies, co-payments, and deductibles. For instance, most of the proposals would provide health insurance coverage to poor people. Nevertheless, disputes will arise, as they do now under Medicaid, over who is "poor" for this purpose within loosely defined legislative parameters. Second, patients will claim a right to receive coverage for certain specific health services. In the past, such claims have been largely decided by indemnity insurance companies that determined whether the services were "medically necessary" as required for insurance or Medicare and Medicaid reimbursement.

Under a reformed system, particularly one that relies on premium payments to health plans, such as health maintenance organizations (HMOs), patient subscribers will not submit claims for payment as they do when they have indemnity coverage. Instead they will ask the plan to provide certain treatment because it is covered by the plan and is medically necessary. They will dispute their plan physicians' decisions to (a) reduce treatment or (b) to reject the patient's request for a particular treatment. Is care in an intensive care unit "medically necessary" for the asthmatic individual who refuses efficacious but disfiguring drug treatment? Is a woman with breast cancer entitled to receive, on an experimental basis, bone marrow transplant treatment customarily used only for patients with leukemia? Is an eighty year old man entitled to receive an organ transplant when "medically necessary" transplants are covered by his health plan? All of these situations raise difficult process and ethical questions in which non-medical factors must be weighed to determine what is medically necessary for coverage purposes. After the enactment of some form of universal health care coverage, patients will base such individual claims to care on both


their statutory entitlement to mandatory coverage and their private insurance contracts. 18

Third, individuals will claim they are entitled to receive treatment of particular quality. 19 Patients who file malpractice claims may assert that under new health care legislation they are entitled to a standard of care different, and perhaps higher and more expensive, than that embodied in state tort law. 20 Sometimes patients will claim they are entitled to use the services of certain doctors, hospitals and clinics, particularly when these providers are especially skilled in providing the care they need. In addition, patients will assert a right to choose among equally efficacious treatments even when some are more costly than others. For example, are parents of a cerebral palsied child entitled to nurses and attendants necessary to care for her at home, or must the parents accept less costly institutional care? Furthermore, patients or persons acting on their behalf, will assert a right to refuse care. Can a competent adult with neurological disorder claim a right to receive food and nutrition in the hospital while refusing medication? 21 Again, resolution of such questions requires an ethical and rational process.

Finally, the legislative promotion of HMOs and other alternative delivery systems that provide both insurance and health care services through a single entity carries with it a number of financial effects. Such systems create financial incentives for stricter distributive rationing and the withholding of costly treatments that affect the quality of care patients receive. Can consumers claim entitlement to the standard of care prevailing under state malpractice law that is higher than that provided by federally sponsored HMOs meeting federal

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20 Various health care reforms would also change current state malpractice law in several ways. Some would impose limitations on the amount of recovery for non-economic loss, eliminate punitive damages, and limit lawyers contingency fees. See generally Symposium, Medical Malpractice: Lessons for Reform, 54 LAW & CONTEMP. PROBS. Nos. 1 & 2 (Winter & Spring 1991). President Clinton’s Health Security Act included “enterprise liability” as a demonstration project. This approach would have made health plans solely responsible for the malpractice of doctors and other health care personnel working for the plans. See William M. Sage, Kathleen E. Hastings, Robert A. Berenson, Enterprise Liability for Medical Malpractice and Health Care Quality Improvement, 20 AM. J. L. & MED. 1 (1994). See also Malpractice Symposium, 49 LAW & CONTEMP. PROBS. No. 2 (Spring 1986); Frank A. Sloan, State Responses to the Malpractice “Crisis” of the 1970’s: An Empirical Assessment, 9 J. HEALTH & HOSP. L. 629 (1985).

21 Cf. Bouvia v. Superior Court, 225 Cal. Rptr. 297 (Ct. App. 1986) (competent adult entitled to receive treatment for pain, but can refuse life sustaining medical treatment, including food and nutrition, from a public hospital).
standards? In such a climate consumer claims will become a critically important vehicle for the formation of health policy.

C. Decision Making Models

At least three models of adjudication are commonly used to make distributive decisions about who gets how much of a given pie. In the negotiation model, opposing parties agree on settlements by trading their interests and bargaining to a result that each values more highly than the status quo. This model, based on micro-economic concepts of efficiency and the enhancement of value through exchange, is used in mediation offered or required by some health plans and required in some courts before parties may litigate their differences. In disputes between patients and health care providers, bargaining can be distributive (dividing a finite pool of resources among the parties) or integrative (open to the parties' adding new resources to be divided among them). Both distributive and integrative bargaining require trading interests to achieve equilibrium. Collective bargaining agreements between organized labor and employers are an example.

In the collaborative model a variety of parties with different interests are represented and resolution is reached through deliberation and consensus. Hospital ethics committees and some administrative agencies' proceedings are examples. Some courts have utilized the collaborative model when required to frame remedial orders in institutional reform litigation. For example, courts have invited amicus participation by professional associations, appointed special masters, and retained court appointed experts to bring patient, medical, psychiatric, administrative and state perspectives to bear on the question of how state mental institutions and prisons could meet their

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22 See, e.g., FURROW ET AL., HEALTH LAW CASES AND MATERIALS, 719 (2d ed. 1991) (discussing the unpublished opinion in Bush v. Dake, File No. 86-25767, NM-2, Circuit Court, County of Saginaw (Mich. 1989), in which an HMO's policy of paying plan physicians funds remaining in "referral" account at end of year was challenged as creating disincentives for proper referrals and good care, but was upheld as not contrary to public policy).

23 See generally ROGER FISHER & WILLIAM URY, GETTING TO YES (1981).


26 In re Quinlan, 355 A.2d 647 (N.J.), cert. denied, 429 U.S. 922 (1976) (requiring that the guardian of a comatose adult confer with the hospital ethics committee before withdrawing life support).

27 Administrative Dispute Resolution Act (previously the Negotiated Rule Making Act of 1990), 5 U.S.C. §§ 581-590 (Supp. 1992) (establishing procedures to be used by administrative agencies that choose to formulate proposed rules through a negotiated rule making process in which affected parties participate).
constitutional and statutory obligations to provide treatment. The adversary model assumes a polarized, zero sum game in which one side can win only to the extent that the other side loses. The model requires the parties to provide evidence of relevant facts to a neutral, passive decision maker who bases his or her decision exclusively on the evidence submitted by the parties and then applies the law (found in constitutions, statutes, administrative rulings and judicial precedents) to the facts found. This model is the one usually used by courts and, in modified form, by administrative agencies.

It could be argued that the claims of patient/consumers for more, better or specific treatment under a reformed health care system should not be resolved exclusively by any one of the models discussed above. Rather, a mixture of the models could be used so that different kinds of claims could be heard in different forums using different decision making processes. However, it could be hard, on a practical level, to classify claims for disposition through the resolution model best suited to resolve them.

For instance, one basis upon which to differentiate claims could be the legal basis or the legal cause of action asserted. Common law tort claims could be tried in adversary proceedings in state courts while disputes involving statutory entitlement would be heard initially in administrative proceedings. Yet, because it is likely that several causes of action will be claimed in a single dispute, cases cannot easily be allocated to various adjudicatory forums on the basis of the source of the legal claim asserted. Alternatively, claims might be differentiated on the basis of the parties involved, with claims against private plans and providers resolved through alternative dispute resolution and claims against the state and federal government addressed in administrative and judicial proceedings. Again, because it is likely that many disputes will involve both public and private actors, an allocation of jurisdiction based on the identity of the parties would be problematic. Finally, claim size could be used as a criterion for the allocation of disputes to small claims courts, state courts and federal courts, as well as within administrative agencies (e.g., Medicare).

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Part A and Part B appeals). Such differentiation seems inappropriate where some claims will be for injunctive relief and others will involve small amounts of money but significant personal values. Unless some differentiating criteria can be found that can be economically and feasibly administered, a unitary system should be considered.

D. Process Values

In designing a claims system based on any of the models discussed, policy makers should be aware that each of the models furthers certain values, either instrumental values or intrinsic values. Some process has "instrumental" value in that it facilitates the accurate application of general, substantive rules to particular facts. For example, in the adversary model, the requirement of notice and opportunity to make written submissions permits the decision maker to obtain information with which to accurately determine particular facts and apply substantive rules to them.31

On the other hand, certain process can be said to have "intrinsic" value to the participants. Thus, an opportunity to be present at a hearing and make an oral statement enhances the participant's sense of dignity and respect for government, apart from its instrumental ability to promote accurate applications of law to facts.32 In the negotiation model, court approved settlements that are bargained for by the parties depend for their legitimacy on principles of individual autonomy and freedom of contract, rather than concepts of public law and justice.33 The consensus model can be seen as grounded in intrinsic values of community, beneficence, rational deliberation, and collective decision making.

A proper approach demands that each of the mechanisms that could be used to resolve patient claims under new health reform legislation be analyzed to identify the process values it promotes. These different process values should then be evaluated to determine whether they further or retard the reform's objectives.

31Mathews v. Eldridge, 424 U.S. 319 (1976); see also Lawrence Tribe, American Constitutional Law, 1365 (2d ed. 1988).

32Jerry L. Mashaw, Due Process in the Administrative State 158-238 (1985); Mashaw, Due Process Calculus, supra note 8, at 41-42. An eloquent discussion of this issue is presented by Judge Patricia Wald in Gray Panthers v. Schweiker, 652 F.2d 146, 162-63 (D.C. Cir. 1980).

Health care reform is intended to further certain values such as autonomy, equity, efficiency, and beneficence. For instance, most health care reform proposals are based on principles of patient autonomy and informed consent. These values are furthered by the accumulation of, and access to, information about the quality and outcomes of care. Similarly, equity among beneficiaries in the form of nationally uniform access, without regard to income or health status, is furthered by affordable or mandated insurance, community rating, and subsidies for low income individuals and small businesses. Efficiency is promoted through the definition and containment of health care costs through market incentives or direct regulation. Beneficence is reflected in the provision of a uniform, broad package of comprehensive benefits to all subscribers.

Application of any given procedure will make the promotion of specific health reform goals more or less likely. An ethics committee that does not provide adequate notice or opportunity for patients to participate effectively does not promote patient autonomy, but may permit the participation of other persons with affected interests and so promote deliberation and the application of community norms. An adversarial, malpractice proceeding may respect the autonomy and dignity of patients, but be institutionally incapable of providing the decision maker with the economic information necessary to make rational decisions about quality of care standards affecting the cost of health care. Whatever process policy makers choose to incorporate in a new health care system should be understood in relation to the values and health care goals that the process itself will further or retard.

Presently, patients may dispute decisions regarding their health care in many different forums. They may make claims against doctors and hospitals, HMOs, private insurers, and government agencies based on breach of contract, statutory violations, or even deprivation of constitutional rights to certain kinds of treatment. Sometimes consumer demands are made directly to

34 See generally Norman Daniels, Just Health Care (1985).


36 For an example of judicial standard setting in the absence of basic economic information see Helling v. Carey, 519 P.2d 981 (Wash. 1974) (requiring glaucoma tests for persons under 40 years old despite evidence that only one out of every 25,000 people under age 40 develop the disease).

providers, and they are decided by nursing home ombudsmen, hospital ethics committees, and institutional grievance procedures.\textsuperscript{38} Sometimes they are made to HMOs, indemnity insurers, or self-insuring employers who provide internal review and appeals procedures.\textsuperscript{39} In other circumstances, claims are directed to government agencies administering public health programs, such as Medicaid or Medicare, and are resolved in hearings before administrative law judges and appeals councils.\textsuperscript{40} The relationship among these forums for dispute resolution is complex.\textsuperscript{41}

Under the major health care reform initiatives presently being considered many private disputes between patients and providers or their insurers will be transformed into public law issues. In these disputes, consumers will claim new rights and entitlements arising under reform legislation. For example, patients who believe their insurance companies have unfairly processed their claims now use a private insurer's grievance procedure or bring bad faith breach of contract actions in state court.\textsuperscript{42} Under a new system of mandatory, publicly supported, federally regulated private health insurance, such claimants might assert a federal cause of action in federal court under 42 U.S.C. § 1983 for deprivation under color of state law of their new right arising under baby); Dixon v. Weinberger, 405 F. Supp. 974 (D.D.C. 1975) (upholding confined mental patient's right to medical treatment in facilities outside of their institution where such treatment is consistent with the rehabilitative purposes of the Hospitalization of the Mentally Ill Act); Thompson v. Sun City Community Hosp., Inc., 688 P.2d 605 (Ariz. 1984) (upholding mother's claim against hospital and physicians for enhancement of injury where hospital transferred son to county hospital for surgery); Hiser v. Randolph, 617 P.2d 774 (Ariz. 1980) (reversing summary judgment in favor of hospital employed physician who refused to provide treatment to a private patient where a substantial fact issue existed as to whether a 40 minute delay occasioned by the physician's refusal, in probability, proximately caused her death).

\textsuperscript{38} See generally John C. Fletcher, Ethics Committees and Due Process, 20 LAW, MED. AND HEALTH CARE 291 (1992); Susan M. Wolf, Ethics Committees and the Courts, HASTINGS CENTER REP., 12 (June 1986).


\textsuperscript{40} Schweiker v. McClure, 456 U.S. 188 (1982) (upholding the constitutionality of the Administrative Hearings procedure available under Part B of the Medicare program which covers Supplementary Medical Costs); Gray Panthers v. Schweiker, 652 F.2d 146 (D.C. Cir. 1980) (holding that the Administrative Hearings procedures under the Medicare program for resolving disputes involving less than one hundred dollars violated the notice and opportunity to be heard requirements of the due process clause).


\textsuperscript{42} Such state tort law claims have been held preempted by ERISA when made against employee benefit plans covered by ERISA. See Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41 (1987).
a federal health care statute, requiring a reconciliation of the Employment Retirement Income Security Act (ERISA) and reform provisions.

Policy makers must consciously decide whether the newly claimed rights should be enforced through adversarial proceedings in federal courts. In doing so they should consider whether such process will further both desirable process values (such as individual autonomy and respect for government) and substantive values of health care reform (such as equity and beneficence), or whether other forums are more appropriate for the resolution of some patient disputes. The following alternative forums should be evaluated in terms of the decision making models they use, the process values they promote, and their ability to achieve the formulation of health policy consistent with the goals of reform.

A. Informal Dispute Resolution

The initial consideration of patient claims for non-emergency medically necessary treatment might take place in informal private or quasi-public forums such as those provided by indemnity insurance companies, Blue Cross/Blue Shield plans, HMOs, or other health plans. In addition to the claimant and the provider, the proceedings in these forums might involve persons representing various other interests affected by the decision. The disposition of claims regarding medical care can be important to such diverse parties as family members, caretakers, professional providers, social workers, hospitals and other institutional providers, insurers, administrators, and ethicists. The process used might be established and varied by contract and be sponsored by health plans, provider organizations, or consumer associations other than the plans whose benefits are at issue. These forums could utilize any one, or a combination of the three, decision making processes (consensus,

43Wilder v. Northern Va. Hosp. Ass'n, 496 U.S. 498 (1990) (the Boren Amendment to the Medicaid Act is enforceable in a §1983 action for declaratory and injunctive relief brought by health care providers); See also Smith v. Heckler, 747 F.2d 583 (10th Cir. 1984) (ruling in favor of plaintiff's §1983 action by holding that the Secretary of Health and Human Services has a statutory duty under the Medicaid Act to develop and implement a system of providing medicaid beneficiaries with the high quality of care intended under the Act), rev'd sub nom. Estate of Smith v. O'Halloran, 930 F.2d 1496 (10th Cir. 1991); Cook v. Ochsner Found. Hosp., 61 F.R.D. 354 (E.D. La. 1972) (upholding Plaintiff's §1983 claim against state hospitals for violations of provisions contained in the federal Hill-Burton Act). But see Suter v. Artist M, 112 S. Ct. 1360 (1992) (§1983 is not available to enforce a violation of a federal statute where Congress has foreclosed enforcement in the enactment itself and "where the statute did not create enforceable rights, privileges, or immunities within the meaning of §1983"). Id. at 1366.

44See Rosenblatt, supra note 6, at 439.

45President Clinton's proposed Health Security Act, for instance, permitted individual patients to file claims with their health plans for payment or the provision of services and requires the plan to notify the claimant of its determination within 30 days, together with an explanation of its decision making process. H.R. 3600 Subtitle C, Part I, 103rd Cong., 1st Sess. (1993).
mediation and/or non-binding arbitration) to help bring about settlements without formal adjudication by government administrative agencies or courts. However, such informal mechanisms for resolving disputes need not be mandatory or preclude administrative or judicial remedies. Their low cost, potential for expeditious resolutions and availability to consumers unassisted by lawyers would further the efficiency and accessibility goals of health care reform.

B. State and Federal Administrative Process: Equity and Expertise

Additionally, or alternatively, state or federal administrative agencies can provide similar informal procedures for the resolution of patient disputes.\(^6\) The scope of such procedures must take into account the fact that the Constitution places some restrictions on the kinds of procedures government agencies may use to adjudicate private interests.\(^7\) For instance, in disputes between private interests and the state, the due process clauses of the fifth and fourteenth amendments require that the usefulness of various procedural elements in providing accurate decisions be weighed against their effect upon the private interests at stake and the government’s interest, including its financial and administrative burdens.\(^8\) While notice and the opportunity for a fair hearing is required by due process, the kind of notice, type of hearing and timing of the hearings depend on the weighing of the interests involved.\(^9\) Like existing administrative remedies provided in the Social Security system and state welfare systems, these administrative forums could provide informal hearings, tape recorded transcripts, determinations made by hearing officers, and review within the agency.\(^{50}\) In suits between private parties adjudicated before state agencies, such as Workers’ Compensation Boards, similar proce-

\(^{46}\) See generally Charles D. Grassley & Charles Pou, Jr., Congress, the Executive Branch and The Dispute Resolution Process, 1992 J. OF DISP. RESOL. 1 (discussing dispute resolution alternatives in administrative proceedings).


\(^{50}\) See generally Margaret G. Farrell, Administrative Paternalism: Social Security’s Representative Payment Program and Two Models of Justice, 14 CARDOZO L. REV. 283 (1992); Farrell, Doing Unto Others, supra note 25, at 891-93. In the case of claims made under health care reform legislation, hearing officers might be required to have special training in health care matters.
dures could be followed. Where the health policies affected need not be nationally uniform, state agencies could provide administrative hearings adjudicating health care claims subject to review by state courts.

However, effectuation of some substantive goals of health care reform requires national uniformity. For instance, equal access to needed care, a major goal of most reform proposals, would seem to require nationally uniform standards for entitlement determinations, and only small differences in eligibility should be tolerated among the states. On the other hand, cost reduction, another important goal of the reform proposals, does not require nationally uniform prices. Thus, a larger degree of variation in private and state resolutions of claims that raise issues of cost is tolerable.

Even where nationally uniform policy is desirable, however, state agency adjudication might be acceptable if reviewed by a federal agency or federal district court. If the only judicial review available were state court review under state administrative procedure acts, only the United States Supreme Court could impose needed national uniformity by reviewing final and appealable state court determinations. In light of the relatively few opportunities to present issues to the Supreme Court, national uniformity must be achieved at a lower level.

To meet the need for uniformity a federal administrative agency could be established to review and make consistent the adjudications of state administrative agencies, or initial jurisdiction could be vested in federal courts. A federal agency could take several forms. The ultimate form selected could be patterned on (1) an independent regulatory commission or board such as the Securities and Exchange Commission, (2) an expert adjudicatory body or Article I court similar to the Tax Court; or (3) an expert advisory body within a cabinet agency such as the Social Security Appeals Council. All of these administration models could use adjudicators who have special expertise in health care issues to make initial determinations. They also permit federal appellate court judges to bring their generalist wisdom to bear on agency decisions through judicial review based on a substantial evidence and abuse of discretion standard.

The values promoted by national uniformity, specialized expertise, and formal procedures should be identified and analyzed for their congruence with the goals of health care reform. Whether health care expertise in initial determinations is a value that is necessary to further a specific goal of health reform is a question that needs to be addressed before policy makers decide whether to give de novo jurisdiction over patient claims to expert administrative agencies or to generalist judges. For example, if an important goal of reform is the humanization of care, then the specialized knowledge of expert decision makers may be less important than the community norms reflected in the views of lay decision makers such as administrative law judges.

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generalist judges, and lay juries. If, on the other hand, administrative efficiency, physiological efficacy and successful use of high technology are important goals, independent administrative agencies staffed by people with medical training and expertise in health care delivery may be more desirable. In order to protect such expert agencies from congressional and executive pressures, an independent regulatory agency could be created to make health policy.

C. An Independent National Health Board—Unaccountable Experts

The term "independent agency" is usually used to describe an administrative agency with a multimember board or commission whose members are appointed by the executive and may not be removed except for cause. Legislative limitations on the authority of the executive to remove members at will is seen as a means of insulating agencies from political pressures exerted through the executive to better assure agency independence. Agencies such as the Securities and Exchange Commission, the Federal Reserve Board and the Interstate Commerce Commission are examples. There is considerable debate among scholars and commentators about the success of independent agencies in exercising authority free of political and other outside influences. Some commentators believe that these independent regulators, in fact, become the captives of those they were intended to regulate. Others find that independent agencies become creatures of Congress and congressional committees that influence their action through congressional oversight and budgetary authority. Other ways in which Congress can insulate agencies from executive influence is by exempting their budgets from review by the Office of Management and Budget and giving agencies authority to enforce their adjudicatory determinations directly through the courts without the approval or participation of the Department of Justice.

Independent agencies are often created to permit experts to render objective decisions about complex economic and technical matters. Such agencies typically exercise the powers of all three branches of government: rule making, adjudication, and enforcement powers. The constitutionality of such agencies

52Humphrey's Executor v. United States, 295 U.S. 602, 629 (1935) (the extent of the President's removal powers depends upon the character of the office; the executive office has unlimited removal power only with respect to purely executive officers and has no removal power over non-executive officers except for one or more of the causes enumerated in the applicable statute).


has been upheld against claims that their authority violates the separation of powers doctrine.\(^{56}\) Recent cases clearly establish that independent agencies may adjudicate the rights of private parties who appear before them contesting either agency or private action. They may constitutionally exercise their own enforcement authority, including the issuance of cease and desist orders.\(^{57}\) Therefore, it would be constitutionally permissible to establish an independent federal board to review the administrative resolution of patient claims.

Whether the establishment of an independent national health board is desirable depends on whether it furthers the goals of health reform. One of the major reasons to create an independent board would be to establish an expert, impartial adjudicator of disputes that will arise. Health care reform proposals could provide that other policy making functions, such as establishing budgets, defining benefits, setting quality standards, and supervising state implementation be carried out by other agencies through their rule making authority. When challenged or applied as the basis for enforcement actions, the rules of other agencies could also be reviewed through adjudication by an independent health board. Finally, disputes between federal agencies, between federal agencies and the states, between states, between private actors (subscribers and providers) and between the states and the federal government could also be given initial hearing before an independent health board. If the health board were to have only such adjudicatory authority, it would function like an Article I court, i.e., a court created by Congress pursuant to its power under Article I to regulate interstate commerce and spend for the public welfare.

Such a system would be distinct from an Article III Court created by Congress pursuant to its authority to create a federal judiciary comprised of judges with lifetime tenure. Appeals from the health board or specialized Article I court would be to a federal circuit court of appeals.\(^{58}\) There is strong sentiment in some circles that resists the creation of specialized courts and

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\(^{56}\)Humphrey's Executor, 295 U.S. at 602 (1935).


\(^{58}\)Due process required by the Fifth and Fourteenth Amendments does not require de novo adjudication of factual and legal claims by Article III courts. Crowell v. Benson, 285 U.S. 22 (1932) (upholding federal Longshoremen's Harbor Workers' Compensation Act provision permitting federal agency official to make determinations of law and fact reviewable on a substantial evidence standard in the federal district courts), overruled in part by Director, O.W.C.P. v. Perini N. River Ass'n, 459 U.S. 297 (1983). Since the judges on such a board or Article I court would not have to be given life tenure or non-reducible salaries, theoretically their judgments would be less insulated against bias than those of Article III courts. Whether Article III safeguards are necessary depends on whether the neutrality of persons who will review agency adjudication of patient health care claims is a process value necessary to carry out the objectives of the reform.
favors retaining and utilizing a system of generalist judges even for the resolution of scientific disputes. In the case of health care claims, the process values of each need to be weighed against their effect on uniform goals.

D. A Board Within an Agency: Accountable Experts

Alternatively, it would be possible to create an expert health board and house it in an executive department rather than establish it as an independent regulatory agency. Logically, an expert health care board would be created under the authority of the Department of Health and Human Services (HHS). Housed in HHS, the board's actions, like all of the agency's actions, would be subject to the approval of the Secretary and in that sense be advisory only.

The Social Security Board might serve as a model upon which to develop an expert health board representing the interest of states, other concerned federal agencies, and the public to advise the Secretary on policy matters. A separate adjudicatory body, like the Social Security Appeals Council, might be set up within HHS to make final determinations on health care claims appealed from state agencies or decided initially within HHS subject only to approval of the Secretary. This administrative model permits the exercise of expert judgment without insulating the decision makers from responsibility to the electorate. Agencies such as HHS are made accountable through the President's power to remove the Secretary at will. Such an administrative model has the advantages of providing a single accountable person, the Secretary of HHS, while still providing the specialized health care expertise of the agency's staff. Whether health care reformists choose such an administrative model should depend on how important expertise and accountability are to the success of the programs they propose.

E. Original Actions in the Federal Courts: Neutral, Generalist, Judges

Finally, if health care reform is enacted at the federal level, it is important for claimants to have access to the federal courts at some point in an adjudicatory process in order to provide uniformity where it is essential to reform goals. The need for federal jurisdiction is suggested by several factors. First, since states will have a major role in implementing many health care reform proposals, individual claims against the system will often implicate legal responsibilities of the states to comply with federal requirements in administering the standards applicable to employers, health plans, insurers, and providers. Second, it may be unrealistic to ask state courts to rigorously hold state governments to federal standards, particularly standards that have significant effect on state budgets. Finally, state courts may create conflicting state precedents which obstruct the achievement of nationally uniform results.

If access to federal courts is to be provided in the interest of nationally uniform policy development, that access could be provided by either de novo hearings before district court judges or appellate review of administrative proceedings as discussed above. Federal district court jurisdiction can be based on diversity of citizenship or presentation of a federal question cause of action. A private cause of action might be expressly provided for in federal health care reform legislation. Such a provision would negate all doubt as to the propriety of providing federal question jurisdiction.

Even if it is not expressly granted, 42 U.S.C. § 1983 (hereinafter § 1983) may provide a federal cause of action for deprivations under color of state law of rights secured by the Constitution and laws of the United States. Whether there is a cause of action under § 1983 to claim newly created rights to health care, cannot be determined without an analysis of the specific health care reform legislation in question. However, strong arguments can be made in support of such jurisdiction. Unless expressly modified in reform legislation, § 1983 would likely permit individual subscribers, enrollees and patients to bring suit in the federal courts against individuals who have, under color of state law, deprived them of a right secured by new federal health care reform legislation.

In the past, persons seeking to secure the administrative enforcement of federally created entitlements under the Hill-Burton Act, the Medicaid Act, the Education of the Handicapped Act and the AFDC provisions of the Social Security Act have relied on § 1983 to assert a private right of action not expressly granted by the federal statutes in question. Under § 1983, private individuals as well as public officials may be held personally liable so long as their actions are taken under color of state law. Actions under color of state law for the purposes of § 1983 include more than the actions that would constitute "state action" for the purposes of the Fifth and Fourteenth Amendments, and exhaustion of administrative remedies is not required before a § 1983 action.

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60 Wilder v. Virginia Hosp. Ass'n, 496 U.S. 498 (1990), supra n.43 (the Boren Amendment to the Medicaid Act is enforceable in a § 1983 action for declaratory and injunctive relief brought by health care providers); But see Suter v. Artist M, 112 S. Ct. 1360, at 1370 (1992) (holding that children who were beneficiaries of the Adoption Assistance and Child Welfare Act did not have an implied cause of action for private enforcement of the federal act's requirement that states use "reasonable efforts" to prevent removal of children from their homes).


63 Blum v. Yaretsky, 457 U.S. 991, 1004-5 (1982) (articulating a three-factor test applicable when analyzing whether the state action exists in actions under color of state law for purposes of § 1983 claims and thereby distinguishing the term, state action, from that which is used when analyzing claims arising under the Fifth and Fourteenth Amendments).
will lie. However, two recent Supreme Court decision have cast doubt on the application of § 1983 to individuals claiming rights under social welfare statutes.

Designers of reform proposals should determine when access to federal district court judges should be provided. Where it is thought that the adversary process is inappropriate, that expert not generalist decision makers are needed, or that the federal courts cannot handle the number of cases that new health care reform legislation would spawn, modifications in the scope of § 1983 causes of action could be made. While Congress can expressly preclude implied causes of action in the legislation and eliminate causes of action provided by § 1983, some constitutional questions might arise under the Due Process clause, the Seventh Amendment guarantee of jury trials in certain cases, and Article II separation of powers doctrine if individual claimants are not provided with adequate alternative remedies.

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65 See discussion of Suter v. Artist M, 112 S. Ct. 1360, supra n.60; Wilder, 496 U.S. at 498 (holding that § 1983 is inapplicable if statute allegedly violated does not create enforceable rights or if Congress foreclosed such enforcement, statute in enactment itself).

66 Sofie v. Fibreboard Corp., 771 P.2d 711 (Wash. 1989). See, e.g., Mattos v. Thompson, 421 A.2d 190 (Pa. 1980) (holding that delays created by arbitration infringe upon the right to trial by jury). Cf. New York Cent. R.R. Co. v. White, 243 U.S. 188 (1917) (constitutional challenges to the workman's compensation system on the ground that it precludes trial by jury of common law tort claims, have been unsuccessful because workers have been held to consent to a non-jury process when they accept employment); See generally Reynolds et. al., A Constitutional Analysis of the AMA's Medical Liability Project Proposal, 1 CTS., HEALTH SCI. & L. 58 (1990).

67 Even elimination of § 1983 causes of action would not necessarily preclude individuals from suing in the federal courts. Causes of action implied by the legislation could be adjudicated by asserting Fifth Amendment deprivation of federal and/or state constitutional, statutory, or common law rights without due process of law. Bivens v. Six Unknown Agents, 403 U.S. 388, 397 (1971) (upholding Plaintiff's § 1983 action for a violation of the Fourth Amendment while seemingly grounding the Court's opinion on the rationale that "The very essence of civil liberty certainly consists in the right of every individual to claim the protection of the laws, whenever he receives an injury." Marbury v. Madison, 5 U.S. (1 Cranch) 137, 163 (1803). This Court's rationale may arguably be extended to include violations of the Fifth Amendment).
IV. CONCLUSION

Recent focus on restructuring the health care system, at the state as well as the national level, presents a unique opportunity to examine and reform existing adjudicatory mechanisms so that they further health policy objectives. Current procedures, including mediation, arbitration, private grievance procedures and review boards, ethics committees, administrative processes, judicial review, and de novo actions in federal and state courts, should be analyzed to determine what substantive and procedural values they enhance. Then, new processes for resolving claims should be designed that promote the substantive values of health care reform, among them equal access, beneficence, and efficiency. For example, procedures for settling disputes that are available only to people with sufficient funds to hire lawyers may not be consistent with health care reform goals of equal access to care. Similarly, procedures that permit different policy precedents in different states may not be consistent with health care reform objectives such as nationally uniform benefits. The legal parameters bounding the discretion of legislators, regulators, insurers, and providers to design dispute resolution systems can be fairly well defined with relative ease. However, as legal academics and bioethicists are beginning to recognize, the process values and ethical principles that should shape that design have not been well developed.